Clinical 3

Clinical Issues

Coverage, coding, and Medical Review

Objective

The objective of the Clinical Issues chapter is to provide information on Coverage criteria, coding, and medical review related to the prospective payment system for long-term care hospitals (LTCH PPS).

Participants will learn the following by the end of this chapter:

Medicare requirements for inpatient hospital services provided by a long-term care hospital.

The importance of correct ICD-9-CM diagnosis and procedure coding by the long-term care hospital.

Who is responsible for medical review activities for LTCH services.

Impacts of interrupted stays on LTCH medical records systems.

ICD-9-CM coding similarities, differences and areas contractors and/or providers should focus on during and after the implementation of the LTCH PPS.

Background

Clinically related information has not changed with the implementation of the new LTCH prospective payment system, but given the fact that LTCHs are the least understood Medicare provider excluded from payments under the acute care PPS, the following information is being provided.

LTCHs typically furnish extended medical and rehabilitative care for patients who are clinically complex and have multiple acute or chronic conditions.

LTCHs are a heterogeneous (mixed) group of facilities ranging from old tuberculosis and chronic disease hospitals to newer facilities designed primarily to care for ventilator-dependent patients.

Generally, Medicare patients in LTCHs were in an acute care hospital just prior to admission to the LTCH.

LTCHs can offer generalized services. (i.e., chronic disease care and specialized services such as physical rehabilitation or ventilator-dependent care.)

LTCH patients receive a range of acute care hospital and "post-acute care" services, which could include:

- Comprehensive rehabilitation
- Cancer treatment
- Head trauma treatment
- Pain management.

LTCHs must meet several criteria that have clinical implications. LTCHs must:

Meet state licensure requirements for acute care hospitals under section 1886(d)(B)(iv) of the Social Security Act.

Have an average length of stay greater than 25 days.

Have an agreement with the Quality Improvement Organization (QIO) formerly known as the Peer Review Organization (PRO).

Sources and Destinations of LTCH Patients

The vast majority of patients are admitted to an LTCH from an acute care facility with direct admission from the community being second most frequent.

Based on the diagnosis of the patient, discharges vary between Skilled Nursing Facility (SNF), Home Health Agency (HHA), and home.

Please Note:

As established in the Medicare Program Integrity Manual (Rev. 24, 04-05-02), FIs are authorized to conduct medical review of LTCH PPS claims notwithstanding the agreements required between LTCHs and Quality Improvement Organizations (QIO), under the LTCH PPS, for admission and quality review. All FIs are required to conduct data analysis to proactively identify aberrant providers. If data findings indicate LTCH aberrancies, the FI will implement the appropriate progressive corrective actions (PCA).

Specialty Groups of LTCHs by Patient Mix

There is a wide belief that the population of LTCHs is heterogeneous; however, the Centers for Medicare & Medicaid Services (CMS) studies have identified four distinct MDC classifications:

1. Rehabilitation-related services
2. Circulatory problems
3. Mental specialty
4. Multi-specialty

Broad categories of conditions as defined by major diagnostic categories (MDCs) were used to classify LTCHs according to medical conditions of patients. MDCs are the principal diagnostic categorizations used under the inpatient acute care hospital prospective payment system (IPPS).

Most MDCs correspond to a major organ system, though a few correspond to etiology.

LTCH Patient Patterns

Most patients in LTCHs have several diagnosis codes on their Medicare claims. LTCH patients are generally less stable upon admission than patients admitted to other post-acute care facilities.

LTCH Cost and Demographic Patterns

LTCHs have a higher proportion of patient cost associated to ancillary services (i.e., pharmacy, laboratory, and radiology services). They also provide care to a disproportionately large number of Medicare beneficiaries who are eligible because of disability versus age 65 or older.

Patient Classification System

The Balanced Budget Reduction Act, better known as the BBRA, required the use of diagnostic-related groups (DRGs) for patient classification in the PPS for LTCHs.

As a result of the BBRA requirement to use DRGs for patient classification in the PPS for LTCHs, CMS developed a patient classification system called Long-Term Care DRGs (LTC-DRGs). LTC-DRGs, like their IPPS-DRG counterparts, are based on broad categories of conditions as defined by major diagnostic categories or MDCs.

Major Diagnostic Categories

MDCs classify services according to the medical conditions of patients.

The MDC is a diagnostic categorization tool. The MDC is the heading under which several DRGs are classified. Each MDC is usually based on a single organ system and in general, a particular medical specialty. For example, diseases of the kidney are not mixed in with (classified with) diseases of the circulatory system (heart and blood vessels).

The principal diagnosis determines MDC assignment. Within all MDCs, cases are divided into surgical and medical DRGs.

Surgical DRGs

Note: 86.11, biopsy of skin and subcutaneous tissue is not considered a surgical DRG.

Surgical DRGs are assigned to discharges that have a procedure of some significance performed (not EKGs, scans or phlebotomy, etc.). Surgical DRGs are assigned based on surgical hierarchy that orders individual procedures or groups of procedures by resource intensity.

Medical DRGs

Medical DRGs do not have significant procedures performed.

EKG or minor surgical procedures generally not performed in the operating room are considered to be medical DRG rather than surgical DRGs.

Secondary diagnosis, age, sex and discharge status also play an important role in the final LTC-DRG assigned.

Long-Term Care Diagnosis Related Groups

LTC-DRGs are based on existing DRGs under the IPPS. As with the IPPS DRGs, assignment of discharges to LTC-DRGS are grouped using ICD-9-CM codes. The LTC-DRGs are weighted to account for the differences in the resources used to treat medically complex LTCH patients. LTCH specific relative weights also account for the fact that LTCHs generally treat multiple medical problems. The LTC-DRG assignment is based on the LTCH discharge date to ensure it appropriately assigned

Assignment of Discharges to LTC-DRGs

Each discharge from an LTCH is assigned only one LTC-DRG.

Patient discharges will be grouped using ICD-9-CM codes based on principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as, age, sex, and discharge status of the patient.

A Medicare patient in a long-term care hospital is considered discharged when:

The patient is formally released (CFR Pat 42 §412.23(e)(3)).

The patient stops receiving Medicare-covered long-term care services (CFR Part 42 §412.521(b)); or

The patient dies in the long-term care facility.

Reference

A list of LTC-DRGs can be found in *Federal Register*/Vol. 67, No. 169/Friday, August 30, 2002/Rules and Regulations, Table 3, starting on page 56076.

Coding and Editing

Diagnostic and procedure information from the patient's hospital record is reported using ICD-9-CM codes on the uniform billing form currently in use. The ICD-9-CM coding system is the basis for IPPS DRGs and now LTC-DRGs.

Because the assignment of a case to a specific LTC-DRG is the basis for the amount paid for the case, **it is mandatory that ICD-9-CM coding be accurate.**

Medicare Fiscal Intermediaries enter the clinical and demographic information submitted by providers into their claims processing systems and subject it to a front-end automated screening process called the Medicare Code Editor (MCE). The screens identify cases that require further review before assignment into a DRG can be made.

ICD-9-CM Coding System

The ICD-9-CM coding system is the basis for CMS DRGs and now long-term care (LTC) DRGs.

All changes to the ICD-9-CM coding system that affect DRG assignment are addressed annually in the acute care hospital inpatient prospective payment system proposed and final rule.

Approved ICD-9-CM code changes become effective at the beginning of the Federal fiscal year, October 1. Since LTC-DRGs are based on acute care DRGs, the annual acute care changes would affect LTC-DRGs.

Claims with invalid ICD-9-CM diagnosis codes will not be processed by the Medicare standard claims processing system.

LTCHs should **pay special attention to invalid diagnosis codes and invalid procedure codes** located in the annual proposed and final rules of the acute care hospital inpatient prospective payment system.

As changes occur, LTCHs must obtain and correctly use the most current edition of the ICD-9-CM codes.

Please Remember:

Inappropriate coding of cases can adversely affect the uniformity of cases in each LTC-DRG and affect the facility's payment.

The emphasis on the need for proper coding cannot be overstated.

HIPAA Compliance

ICD-9-CM coding terminology and the definitions of principal and other diagnoses of the Uniform Hospital Discharge Data Set (UHDDS) are consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)(45 CFR part 162).

Principal Diagnosis

The principal diagnosis on a claim determines the Major Diagnostic Category assignment. The following definitions have been approved by the Secretary of Health and Human Services, are requirements of the ICD-9-CM coding system and were used as a standard for the development of CMS DRGs.

Principal Diagnosis Defined:

The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Each bill from an LTCH must contain the complete diagnosis and procedure coding for purposes of the GROUPER software. The principal diagnosis must remain the same on every bill submitted for the LTCH stay. Normal adjustments will be allowed.

It is important to remember that the appropriate principal diagnosis at the LTCH is **not necessarily the same diagnosis patient received care for at the acute care hospital.** Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded both as principal diagnoses and as secondary diagnoses.

Secondary/Other Diagnoses

Secondary Diagnoses Defined:

Other diagnoses, also called secondary diagnoses or additional diagnoses, are defined as all conditions that coexist at the time of admission, that **develop subsequently**, or that affect the treatment received or the length of stay or both.

The concept of capturing diagnoses that develop subsequent to admission is important for data and reimbursement purposes. These additional codes could ultimately change the DRG-LTC to which the stay is assigned.

Any new diagnoses identified subsequent to admission should be reported on the next interim claim and then reported on each and every subsequent adjustment claim through and including the discharge claim.

Procedures

Procedures should be coded based on current ICD-9-CM coding requirements, i.e.; all procedures performed should be reported on the LTCH claim. This includes procedures that are surgical in nature, carry a procedural risk, carry an anesthetic risk, or require specialized training.

Medicare Code Editor

The MCE identifies cases requiring further review based on the clinical and demographic information on the claim. Cases requiring further review include situations such as:

Improperly coded claims (i.e., hysterectomy for a man);

Surgical procedures not covered by Medicare (i.e., organ transplant in a non-approved facility);

Lack of information on claim (i.e., ICD-9-CM codes are required to be entered at their highest level of specificity but code is reported with less than correct number of bytes). MCE will reject this claim.

Principal diagnosis does not justify admission.

Correct Coding Examples

Principal Diagnosis

The appropriate principal diagnosis for the LTCH is not necessarily the same diagnosis for which the patient received care at the acute care hospital.

> Patient is discharged from an acute care facility and admitted to an LTCH.
> Patient suffers a stroke (ICD-9-CM category 436, Acute, but ill-defined cerebrovascular disease) – admitted to acute hospital.
> Patient is discharged and then admitted to an LTCH for further treatment of left-sided hemiparesis and dysphasia.

The appropriate code from the LTCH would be a code from ICD-9-CM diagnosis code 438 (Late affects of cerebrovascular disease), such as ICD-9-CM diagnosis code 438.20 (Late affects of cerebrovascular disease, hemiplegia affecting unspecified side), or ICD-9-CM diagnosis code 438.12 (Late affects of cerebrovascular disease, dysphasia).

Coding guidelines state that the residual condition is sequenced first followed by the cause of the late effect. In the case of a cerebrovascular disease, the combination code describes both the residual of the stroke (example, speech or language deficits or paralysis), and the cause of the residual (the stroke).

ICD-9-CM diagnosis code 436 would only be used for the first (initial) episode of care for the stroke, the admission to the acute care hospital.

When the patient is admitted to the LTCH, the focus of treatment has shifted from identification and treatment of the acute episode to treatment of the sequelae (follow-up) or residual deficits resulting from the acute disease process.

The principal diagnosis must remain the same throughout the entire stay at the LTCH.

Secondary Diagnoses with No Bearing on LTCH Stay

Secondary diagnoses that have no bearing on the LTCH stay should not be coded.

> A patient who has recovered from pneumonia during a previous episode of care would not have a diagnosis code for pneumonia included in the list of discharge diagnoses.

The pneumonia was not treated during the LTCH admission; thus, it has no bearing on the case and **it should not be coded** on the LTCH claim.

Secondary Diagnoses Coded as Conditions Develop

Secondary or additional diagnoses should be coded **as conditions develop**. They should be reported on the next claim and continue to be submitted on all claims including the discharge claim.

> A patient develops a decubiti during the LTCH stay.

Decubiti was not present on admission, but **must be added to the next claim**. It must continue to be displayed on each claim thereafter, even if the decubiti is successfully treated and resolved before the patient's discharge from the LTCH.

Procedure Codes Performed in Acute Care Setting

Codes reflecting procedures provided during a previous acute care hospital stay would not be included on the LTCH claim because the procedure was not performed during the LTCH stay.

> A patient with several chronic illnesses is admitted to an acute care hospital with a diagnosis of appendicitis; an appendectomy is performed.
> Patient is discharge and then admitted to an LTCH for medical treatment following the surgery.
> As a result of multiple secondary conditions, the patient needs a higher level of care than could be provided in a SNF or at home by an HHA.

Appendicitis **should not be coded** because the condition was resolved with the removal of the appendix. In other words, the procedure should not be included on the patient's LTCH claim since it was not performed during the LTCH admission.

Procedures Performed in the LTCH

All procedures performed during the LTCH stay must be reported on the claim.

> A patient is placed on a ventilator at the beginning of LTCH stay, or is placed on a ventilator during the stay, but is subsequently weaned from the ventilator during the stay.

Ventilator code **must be submitted** on the claims, including discharge claim.

> A patient had a laparoscopic lysis of peritoneal adhesions, ICD-9-CM procedure code 54.51.

ICD-9-CM procedure code 54.51 **must be reported** on all claims submitted for the duration of the patient's stay at the LTCH.

Role of the Quality Improvement Organization

LTCHs must have an agreement with a Quality Improvement Organization (QIO), formerly known as the Peer Review Organization (PRO), to have the QIO review the following on an ongoing basis:

The medical necessity, reasonableness, and appropriateness of hospital admission and discharges

Inpatient hospital care for which outlier payments are sought

Validity of the hospital's diagnostic and procedural information

Completeness, adequacy and quality of the services furnished in the hospital

Other medical or other practices with respect to beneficiaries or billing for services furnished to the beneficiaries.

Physician Acknowledgement Statement

Physicians must complete an acknowledgement statement to indicate they understand that Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. The LTCH must maintain this signed acknowledgement for each attending physician.

Content of Physician Acknowledgement Statement

When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice.

Notice to Physicians

"Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

Completion of Acknowledgement

The acknowledgement must be completed by each physician at the time the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient.

Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

Denials Based on Admissions and Quality Review

If CMS determines on the basis of information supplied by a QIO that a hospital has misrepresented admissions, discharges or billing information, or has taken an action that results in unnecessary admission of an individual entitled to benefits under Part A, unnecessary multiple admissions of an individual or other inappropriate medical or other practices with respect to beneficiaries, or billing for services furnished to beneficiaries, CMS may as appropriate:

Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided for an unnecessary admission or subsequent readmission of an individual; or

Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

Medical Review by the FI

As established in the Medicare Program Integrity Manual (Rev. 24, 04-05-02), FIs are authorized to conduct medical review of LTCH PPS claims notwithstanding the agreements required between LTCHs and Quality Improvement Organizations (QIO), under the LTCH PPS, for admission and quality review. All FIs are required to conduct data analysis to proactively identify aberrant providers. If data findings indicate LTCH aberrancies, the FI will implement the appropriate progressive corrective actions (PCA).

For payment purposes, Medicare will not cover any patient stay, even if the patient has remaining Medicare days, if that stay has been determined not to have met the medical necessity, reasonableness, and appropriateness standards of the medical review procedure established under the final rule. In such cases, the days of a stay failing medical review will be excluded from the qualification computation for the LTCH's cost reporting period.

The current Appeal, Right to Hearing and Office of Inspector General guidelines also remain the same.

Furnishing of Inpatient Hospital Services Directly or Under Arrangement

LTCHs must furnish all necessary covered services to Medicare beneficiaries who are inpatients of the hospital either directly or under arrangements.

Medicare will not pay any provider or supplier other than the LTCH for services furnished to a Medicare beneficiary who is an inpatient of the LTCH, except those services not included as inpatient hospital services.

All covered services must be provided by the appropriate clinician. Clinicians providing services to a beneficiary in an LTCH must be licensed and/or credentialed in the state where the service is performed and working within the scope of their license.

A Clinician Is:
An employee of the LTCH or an employee contracted by the LTCH.

Claims for the Part B Carrier

Claims are also submitted to the Part B Carrier based on the clinician providing the service.

Claims for the clinicians listed below should be submitted to the Part B Carrier servicing the facility.

Physician's services

Physician assistant services

Nurse practitioners services

Clinical nurse specialist services

Certified nurse midwife services

Qualified psychologist services

Anesthetist services

Documentation

Generally, LTCHs are distinguished from other inpatient hospital settings by an average length of stay greater than 25 days.

Two special payment situations related to length of stay impact clinicians and/or medical records.

1. **Short-stay outliers** have stays of considerably less than the average length of stay. The patient receives less than the full course of treatment for a specified LTC-DRG and therefore would be paid inappropriately if the hospital were to receive the full LTC-DRG payment.

2. **Interrupted stays** are cases in which an LTCH patient is discharged from the LTCH and admitted to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF) or a swing-bed and ultimately returns to the same LTCH within a fixed period of time. The fixed period of time is defined by the type of facility receiving the beneficiary after discharge from the LTCH. The interrupted stay case is treated as one discharge for the purposes of payment and only one LTCH PPS payment is made.

Short-Stay Outliers

LTCH stays that are between one day and up to and including 5/6 of the geometric average length of stay of the LTC-DRG are considered to be **short-stay**s.

Short-stay outliers may be caused by any of the following clinically-based situations:

It is determined after admission to the LTCH that the beneficiary would receive more appropriate care in another setting: Typically the patient experiences an acute episode or requires more intensive rehabilitation therapy than is available at the LTCH. The patient is then discharged and not subsequently readmitted because they no longer require LTCH-level treatment.

The patient may be discharged to their home.

The patient expires within the first several days of being admitted to an LTCH.

The patient may not require the type of care generally provided in an LTCH.

The patient may require urgent treatment at another site of care.

Obviously, with a short-stay, the beneficiary frequently receives less than the full course of treatment at the LTCH before being discharged.

Medical record documentation should be clear, concise and the support services provided to the beneficiary during their LTCH admission.

Interrupted Stay

Interrupted stays are cases in which an LTCH patient is discharged to another type of facility for services that may not be available at the LTCH and returns to the LTCH for further treatment within a fixed period of time. The fixed periods range from 9 to 45 days depending on the type of facility receiving the discharged LTCH patient.

The fixed periods vary by facility type as follows:

- Inpatient acute care hospital within 9 days
- Inpatient Rehabilitation Facility (IRF) within 27 days
- Swing-bed hospital within 45 days
- Skilled Nursing Facility (SNF) within 45 days

Part of the reasoning behind this policy is that CMS wanted to ensure that any discharge from an LTCH to another Medicare provider that was then followed by a re-admittance to the LTCH was based on clinical considerations, i.e., that the patient received a full course of treatment at the other facility, rather than on financial incentives for another discharge payment.

Cases that meet the interrupted stay criteria are considered a single discharge from the LTCH and therefore only one LTC-DRG payment is made to the LTCH.

This potentially creates an interesting administrative issue for LTCH providers since they must take appropriate steps to ensure that coding and medical record documentation for both admissions are included in the interrupted stay LTC-DRG and that they are available for review. Again, it is also very important that the principal diagnosis reflect the admission principal diagnosis on all claims submitted.

If a request for medical record documentation occurs, the provider should **forward the medical documentation for both admissions included in the interrupted stay claim** to the QIO or FI, as applicable, to support the assigned LTC-DRG.

If an LTCH patient's discharge to an acute care hospital, IRF, Swing-bed or SNF is longer than the specified length of discharge stay for that provider, the subsequent readmission to the LTCH would be considered a new admission, not an interrupted stay. Therefore, the records from the two separate admissions can be maintained separately and the ICD-9-CM coding must be reported independently on two separate claims.